MEDICAL BOARD OF CALIFORNIA

Central Complaint Unit
1426 Howe Avenue
Sacramento, California 95825
1-800-633-2322
(916) 263-2424

Notice: The information included on the complaint form is requested per Section 2220 of the Business and Professions Code. Except for the name of the physician, all information requested is voluntary, but failure to provide the requested information may delay or prevent the investigation of your complaint. As much information as possible should be provided in connection with the complaint. The information on the complaint form will be used in part to determine whether a violation of state law has occurred. If a violation is substantiated, the information may be transmitted to other government agencies, including the Attorney General's Offices.

INSTRUCTIONS FOR COMPLETING THE COMPLAINT FORM

FRONT OF THE COMPLAINT FORM

Clearly **print** or **type** all information. If we have to contact you to clarify your information, it will delay the process.

1. Fill in the full name and address of the person your complaint is against.

2. Fill in your name and address, and the patient's name and birth date.

3. If the patient has seen another doctor for the same problem, include the name and address on the records release section on the back of the complaint form

4. Write your complaint and include as many specific details as possible (who, what, when, where, why). Include the date(s) of treatment and specific examples of the problems with the care and treatment. **Please use extra sheets of paper, if needed, to tell us <u>everything</u>.** Send us copies of any documents in support of your complaint. This may include patient records, photographs, correspondence, billing statements, etc.

5. Sign and date the complaint form at the bottom of the front page.

BACK OF THE COMPLAINT FORM

Complete the medical records release section on the back of the complaint form as follows:

- This document is a legal authorization for the Medical Board's staff to obtain information about the patient's care from the doctors and/or medical facilities involved in the medical care. ***ANY EXTRA COMMENTS, NOTATIONS, ETC., MAKE THE FORM VOID, AND WE WILL HAVE TO ASK YOU TO FILL OUT ANOTHER RELEASE FORM. If you wish to provide us with additional information, please do so on a separate piece of paper.*** If there are more than four physicians or medical facilities, you may copy the blank form in order to have enough spaces. This form, when it is filled out and signed, allows the Medical Board to get records from ONLY the doctors or facilities you list on this medical records release form.

- **Print** or **type** the patient's name, date of birth, date of death and medical record number (if these are applicable). If we have to contact you to clarify your information, it will delay the process.

- Print or type the names and addresses of all health care providers where the patient was seen for the medical problems in this specific complaint (doctors and/or clinics or hospitals, etc.). Put the name of the person you are complaining about in the first section. Then use the other sections for the other places of treatment.

- The release form must be signed and dated **by either the patient or the individual legally authorized to make medical decisions for the patient.** If the patient is unable to sign the release, the form may be signed by: 1) the next of kin, if the patient is deceased (provide a copy of the death certificate), 2) the parent of a minor child, or 3) the person named by the patient in a signed "Power of Attorney" granting the person authority to make **medical decisions** for the patient (provide a copy of this document).

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1426 Howe Avenue, Sacramento CA 95825-3236
1-800-633-2322

CONSUMER COMPLAINT FORM

Please Print or Type

COMPLAINT REGISTERED AGAINST

1. Last Name **First** **Middle Initial**

Office/Facility Name:

Street Address: **City** **County** **State** **Zip Code**

Phone Number: ( )

PERSON REGISTERING COMPLAINT

2. **Mr.** **Last Name** **First** **Middle Initial**
Mrs. Ms.

Mailing Address **City** **County** **State** **Zip Code**

Home phone: ( ) **Daytime phone: ( )**

Your Relationship to Patient:

Patient Name:
Mr. Mrs. Ms.

Patient's Date of Birth:

3. Has patient been examined/treated by another physician for this same condition? Yes No If yes, provide name and address on reverse

DETAILS OF COMPLAINT

4. Reason for Treatment:

Treatment Date(s):

Details of your complaint (attach additional sheets if necessary)

5. Signature_____**Date**_____

****CONTINUE ON REVERSE SIDE****

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

AUTHORIZATION FOR RELEASE OF MEDICAL, PSYCHIATRIC, ALCOHOL OR DRUG ABUSE PATIENT RECORDS

Patient Name: _____ Date of Birth: _____

Medical Record No. _____ (if applicable) Date of Death _____

Social Security No: _____ **(Optional)**

I, the undersigned hereby authorize:

Physician		Physician/ Facility	
Address		Address	
Phone Number		Phone Number	
Treatment Date(s)		Treatment Date(s)	
Physician/ Facility		Physician/ Facility	
Address		Address	
Phone Number		Phone Number	
Treatment Date(s)		Treatment Date(s)	

to disclose records in the course of my diagnosis and treatment, including medical, psychiatric, alcohol and drug abuse records to the **MEDICAL BOARD OF CALIFORNIA, ENFORCEMENT PROGRAM.** This disclosure of records authorized herein is required for official use, including investigation and possible administrative proceedings regarding any violations of the laws of the State of California. This authorization shall remain valid until the Medical Board of California of the State of California completes its investigation and proceedings arising out of the investigation.

A copy of this authorization shall be as valid as the original. I understand that I have a right to receive a copy of this authorization if requested by me.

Signature: _____ _____

Patient Date

or: _____ _____ _____

Legal Representative Relationship Date

NOTE TO THE PROVIDER: Failure by a physician, podiatrist or health care facility to provide the requested records within 15 days of receipt of this request and authorization may constitute a violation of Section 2225.5 of the Medical Practice Act and may result in further action by the Board.